nodules varying in size from a pea to a pecan nut were shelled out with the ungloved finger. Palpation with the finger in each lateral cavity against the retractor in the bladder, and then with the finger in the rectum, demonstrated that the capsule was practically empty; there was no median enlargement. The tractor was then removed and the finger passed through the prostatic urethra to the bladder; there was no obstruction and no stone. A 31 F. sound was passed through the urethra to the bladder and a large perineal drainage-tube inserted and secured. Time of operation, 55 minutes.

The kidneys acted freely after the operation, 240 ounces being passed in 24 hours. The tube was removed and a sound passed on the sixth day. Some elevation of temperature followed, and the tube was replaced four days later and left two days more. On May 7th urine began to pass through the urethra; residual urine about 20 ounces. On May 12th, one month after operation, residual urine was 6 to 8 ounces, and the patient was able to hold his urine from 4 to 6 hours. Sounds were passed every 4 or 5 days. Patient left hospital for his home on May 19th, about 5 weeks after his operation. The perineal wound was nearly closed, but a little urine still escaped. One month later he developed a suppurative phlebitis of right leg, which required incision and drainage, and kept him in bed for some weeks. He now has perfect urinary control; there is still a little moisture at the perineal fistula, but only a drop or two of urine escapes at urination. He is able to retain urine 2 to 4 hours, passing he thinks as much as three-quarters of a pint each time.

The case presented some unusual difficulties; *e.g.*, the great obesity, with poor circulation, and a tendency to cyanosis, increasing the immediate operative and anæsthetic risk; and the high grade of polyuria, which, together with the onset of complete retention, made continuous catheterization impracticable, and operation imperative.

CARCINOMA OF RECTUM TEN YEARS AFTER EXTIRPATION OF ADENOMA OF HEPATIC FLEXURE.

DR. HOWARD LILIENTHAL presented a man of 50 years who was operated on ten years ago for the removal of a tumor of the hepatic flexure which involved the entire ascending colon, part of the transverse colon and six inches of ileum. A resection was

done, and the ileum was anastomosed to the end of the colon by means of a Murphy button. The necessity for the removal of such a large segment of gut was that the ascending cæcum and colon had been drawn up and had become adherent to the adenomatous growth. The patient made an excellent recovery, in spite of his poor general condition at the time of the operation. The excised growth was carefully examined, and proved to be an adenoma.

The patient remained in good health until about one year ago, when he began to complain of pain in the rectum, which was worse on defecation. His stools contained pus and some blood, and there was considerable loss of flesh and strength. Upon examination, Dr. Lilienthal found what he immediately took to be a carcinoma of the anal portion of the rectum, constricting it considerably, and with a number of fissures. A section of the growth removed for microscopic purposes showed adenocarcinoma.

Operation, December 25, 1907. Upon section, the growth was found to extend so high up that it would be impossible to resort to Gersuny's method of twisting the bowel to form a new sphincter after removal of the tumor. The coccyx was removed, and a clamp applied to the rectum about an inch above the tumor; the latter was then pulled down and sewn to the skin, leaving a good-sized opening for drainage. Twelve hours later it was noted that the patient had not passed any urine, and attempts to pass a catheter had failed. This was attributed to accidental injury of the urethra in the course of the operation on the rectum, and before a catheter could be introduced *per urethram* it was found necessary to make a perineal opening pass a catheter from the suprapubic wound through the perineal wound, and insert a sound from the meatus down to the perineal wound. A catheter was then introduced into the bladder through the urethra and left in for ten days. By that time granulations had formed, and the catheter was passed at increasing intervals, and now the patient had no further trouble in passing his urine.

In connection with the rectal operation, Dr. Lilienthal said that in spite of the fact that the ascending colon, part of the transverse colon, and all of his rectum was removed, the patient was still able to hold his stools, although no effort had been made to form a sphincter. By carefully dieting himself and by the

use of subgallate of bismuth, he was able to control his bowels, and had but one passage a day.

CRANIOTOMY FOR TUMOR OF ACOUSTIC NERVE.

DR. WILLY MEYER presented a woman, 23 years old, who was referred to Dr. Meyer by Dr. George W. Jacoby. She had a slight facial palsy on the left side, with drooping of the left eyelid and the corresponding angle of the mouth. She complained chiefly of dizziness and staggering while walking, and swayed on standing. Hearing on the left side was much impaired. There was slight headache; rarely vomiting; choked discs with atrophy.

After careful observation, the case was regarded as one of tumor of the pontocerebellar angle, involving the left auditory and facial nerve, and an operation for its removal was undertaken on January 29, 1908. Preliminary to the operation, the head of the table was elevated, so that the body rested in the inverted Trendelenburg position, with the forehead resting on a special attachment, and hands and feet being supported. Following the suggestion of Dr. Dawbarn, blood was stored in both lower extremities for emergency purposes. Anæsthesia was effected by introducing two long tubes through the nostrils, and administering the anæsthetic through a funnel, a mixture of ether, chloroform, and ethyl chloride being used. In the course of the operation, additional narcotization became necessary, and this was given by means of a mask, with the anæsthetist sitting underneath the operating table. Anæsthesia was very satisfactory throughout.

The occiput was exposed through a large horseshoe incision, extending from one mastoid to the other, and reaching about two fingers' width above the occipital protuberance. This flap was then divided into two equal parts and retracted, thus giving a free exposure of the cerebellar region. After trephining with chisel the bone was removed with the rongeur forceps down to the foramen occipitale, this work being greatly facilitated by first thinning the bone with a large curved chisel. At various points, severe venous hemorrhage was encountered from the divided bone, but this was readily controlled by the application of Horsley's wax. Both lateral sinuses were fully exposed, and at last the bridge of bone in the median line cut through with Gigli saw and removed. Now the dura mater was opened and cut parallel with the border of the divided bone on either side near to the